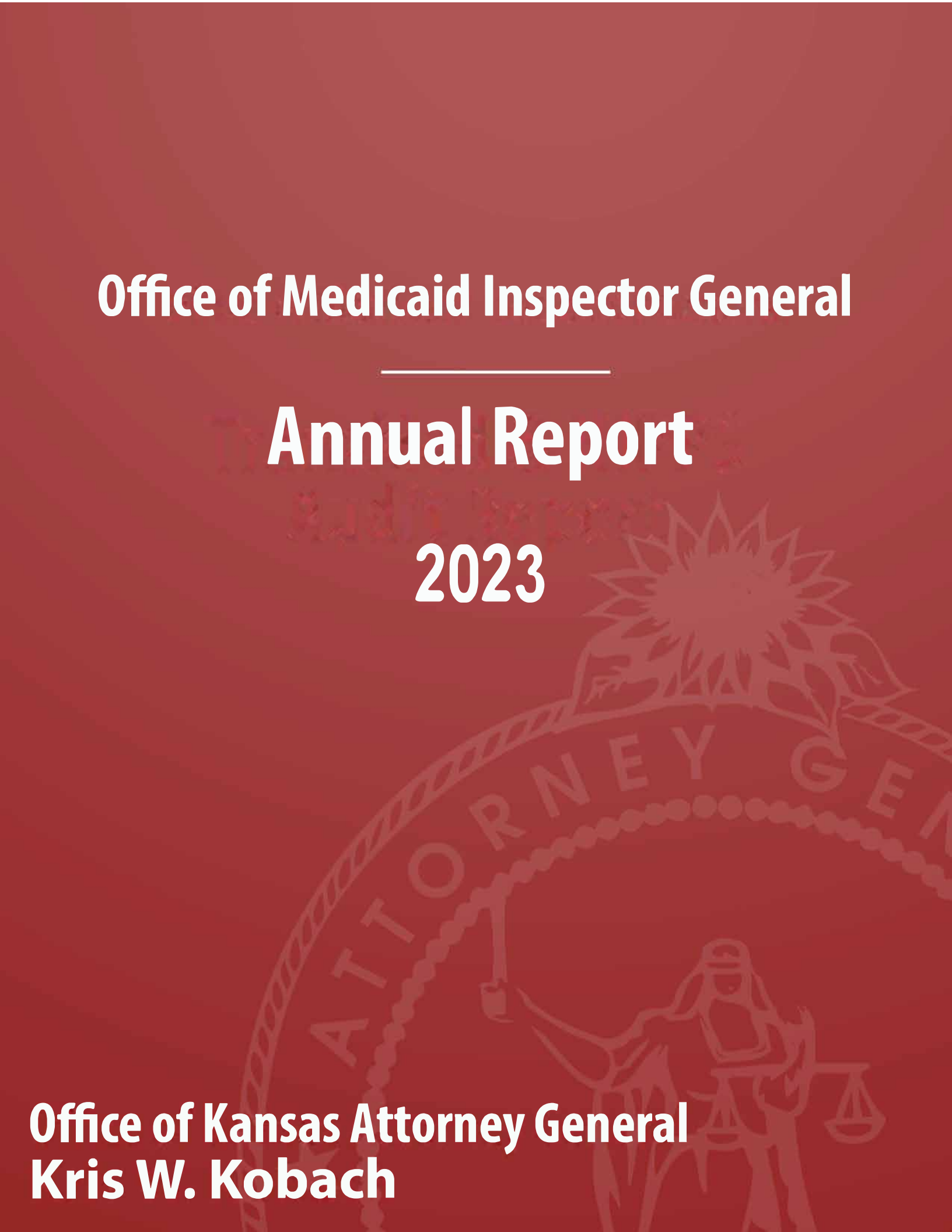
Office of Medicaid Inspector General

Annual Report

2023



Office of Kansas Attorney General
Kris W. Kobach

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Letter from the Inspector General

February 5, 2024

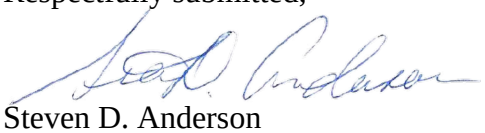
Dear Fellow Kansans:

It is our pleasure to submit the annual report of the Medicaid Inspector General within the Office of Attorney General Kris W. Kobach for calendar year 2023. This report is issued in accordance with K.S.A. 75-7427(i) and is respectfully submitted to:

- The Citizens of the State of Kansas
- Governor Laura Kelly
- Members of the Kansas Senate Committee on Ways and Means
- Members of the Kansas House of Representatives Committee on Appropriations
- Kansas Department of Health and Environment Secretary Janet Stanek
- Kansas Department for Aging and Disability Services Secretary Laura Howard
- Legislative Post Auditor Chris Clarke
- Kansas Attorney General Kris W. Kobach

This report provides an overview of the Kansas Medicaid Inspector General's Office and describes the office's activities during calendar year 2023. We welcome any comments or questions you may have regarding this report or our operations.

Respectfully submitted,



Steven D. Anderson
Medicaid Inspector General

Introduction

The Office of Medicaid Inspector General (OMIG) is charged with overseeing the Kansas Medicaid program (KanCare), the MediKan program, and the State Children's Health Insurance Program (SCHIP). K.S.A. 75-7427(b)(1) states that the purpose of the OMIG is: "*to establish a full-time program of audit, investigation and performance review to provide increased accountability, integrity and oversight . . . and to assist in improving agency and program operations and in deterring and identifying fraud, waste, abuse and illegal acts.*" The same statute requires the Medicaid inspector general to be "*independent and free from political influence*" in performing the duties of the position.

The OMIG is an independent division of the Kansas Attorney General's Office. In accordance with K.S.A. 75-7427(b)(1), *all budgeting, purchasing, related management functions and personnel are administered under the direction and supervision of the attorney general*. In accordance with K.S.A. 75-7427(l), *the scope, timing, and completion of all audits and investigations conducted by the OMIG shall be within the discretion of the Medicaid inspector general*.

Mission Statement: Conduct audits, investigations, and performance reviews to increase accountability, integrity, and oversight of Medicaid, MediKan, and the State Children's Health Insurance Program (SCHIP); assist in improving agency and program operations; and in deterring and identifying fraud, waste, abuse, and illegal acts.

Vision: Pursue positive changes in Kansas Medicaid related programs to better serve the citizens of Kansas.

Goals:

- Prevent, detect, and deter fraud, waste, abuse, and illegal acts
- Identify funds for recovery or recoupment
- Provide suggestions for improving efficiency, effectiveness, and integrity
- Identify and refer criminal/civil matters for prosecution
- Foster sound financial practices and reduction of improper payments

OMIG History

In 2007, Senate Bill 11 created the Office of Inspector General within the Kansas Health Policy Authority (KHPA). The original statutory provisions contained in that bill remain virtually unchanged today.

In 2011, Executive Reorganization Order No. 38 abolished the KHPA and transferred all powers, duties, and functions of the KHPA to the Division of Health Care Finance within the Kansas Department of Health and Environment (KDHE). The OMIG was transferred to KDHE as part of that Executive Reorganization Order.

In January 2014, the last Senate confirmed inspector general under KDHE left their position and the last OMIG staff member left in November 2014. This began a period of the OMIG being vacant until October 2018.

In 2017, Senate Bill 149 transferred the OMIG from KDHE to the attorney general's office effective June 1, 2017. On October 9, 2018, the Senate Confirmation Oversight Committee voted to authorize Sarah Fertig, the attorney general's first nominee for the Medicaid inspector general position, to exercise the powers of the office pending confirmation by the full Senate. Fertig was confirmed by the full Senate in January 2019.

Following Fertig's resignation from the position in July 2020, former Attorney General Derek Schmidt nominated Steven Anderson to be the next Medicaid inspector general on January 21, 2021. On April 6, 2021, Anderson was confirmed as the new Medicaid inspector general by the Senate. Anderson continues to serve as Medicaid inspector general.

OMIG Staffing

Between January and June 2019, the OMIG had one staff member, the Medicaid inspector general. The OMIG hired an auditor in June 2019 and a data analyst in February 2020.
The OMIG began the process of recruiting a new Medicaid inspector general in July 2020 due to the resignation of the former inspector general. In the interim, former Attorney General Derek Schmidt appointed Jay Scott Emler (former Deputy Attorney General/Chief Information Security Officer) to serve as the administrator for OMIG.

Steven Anderson was appointed on January 21, 2021, and confirmed by the full Senate on April 6, 2021.

A part-time secretary was hired August 23, 2021.

Two auditors were added at the end of FY 2022 and employment began on June 13, 2022. They were a critical addition to the OMIG's ability to fulfill part of its core missions of auditing and performance reviews. Two full-time special agents and a financial analyst to conduct investigations of Medicaid eligibility fraud were added beginning FY 2024 in July 2023.

The OMIG currently consists of the IG, three auditors, two analysts, two special agents and a part-time secretary.

Summary of OMIG Activities

Detecting and Preventing Fraud, Waste, Abuse, and Illegal Acts

K.S.A. 75-7427(k)(1) requires the Medicaid inspector general to "make provision to solicit and receive reports of fraud, waste, abuse, and illegal acts." To that end, the attorney general's office created a dedicated email address, MedicaidIG@ag.ks.gov, that concerned citizens may use to submit such reports. The attorney general's office also offers an online form which can be used to report suspected fraud, waste, abuse, and illegal acts related to the programs within the OMIG's jurisdiction.

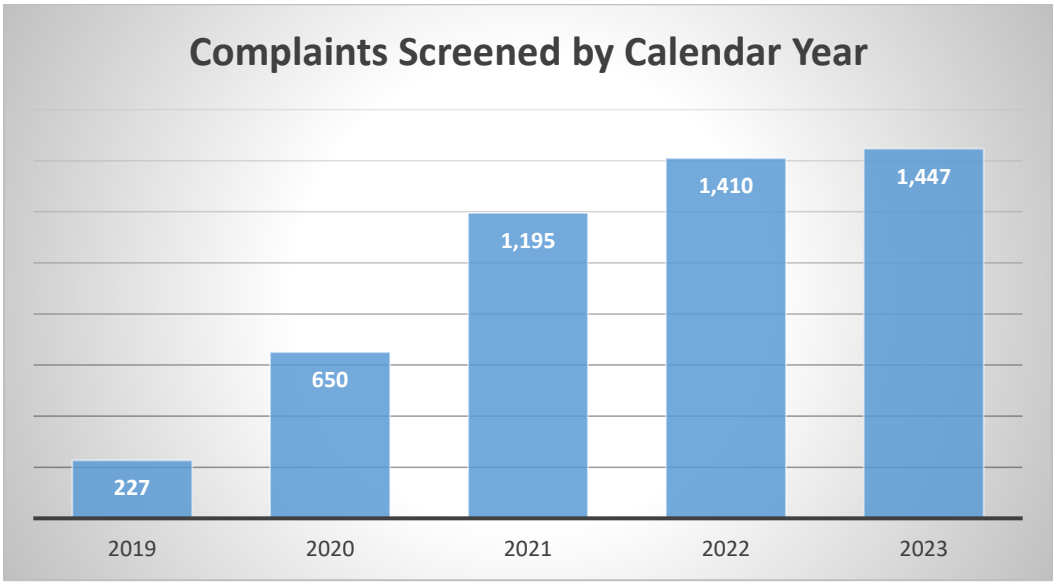
K.S.A. 75-7427(k)(1) also required that the inspector general shall not disclose or make public the identity of any person or persons who provide such reports pursuant to this subsection unless such person or persons consent in writing to the disclosure of such person's identity. Disclosure of the identity of any person who makes a report pursuant to this subsection shall not be ordered as part of any administrative or judicial proceeding.

In cooperation with KDHE, the OMIG developed fraud, waste, and abuse awareness training that was provided to KDHE and contract employees. Last calendar year, we completed six training sessions and provided the training to 196 employees. This calendar year, we conducted 19 training sessions and provided the training to 831 people. The training is offered on an annual basis to KDHE employees and contract employees. Some sessions are open to the public. The purpose of the training is to ensure everyone is better prepared to identify fraud, waste, and abuse and how to report it.

OMIG conducted a review of COVID-19 test kit claims to determine if Kansas Medicaid received fraudulent claims for at-home COVID-19 test kits and if Kansas Medicaid paid any fraudulent claims. We reviewed claims from all providers that billed for at-home test kits from April 1, 2022, through May 31, 2023. There were 548 providers who billed for 247,190 kits totaling $4,119,421.44. Medicaid paid $0 on the claims. We identified that 11 of the 548 providers billed for 32% of the kits. These 11 only billed under code K1034 and did not bill for any other service or supply. While Medicaid did not pay any of the claims, records indicated that Medicare paid $899,811.84. None of the providers are located in Kansas and 9 of the 11 registered for their National Provider Identifier (NPI) numbers after March 2020. The information developed from this review was forwarded to the Health and Human Services Office of Inspector General (HHS/OIG).

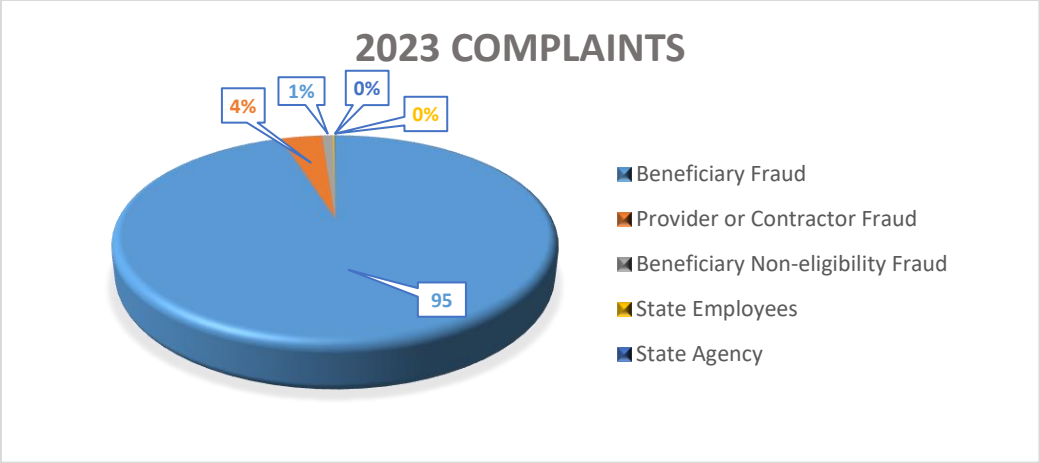
The OMIG continues to oversee an increasing number of complaints of fraud, waste, abuse, and illegal acts concerning the Kansas Medicaid program (KanCare), the MediKan program, and the State Children's Health Insurance Program (SCHIP). The majority of complaints received are

submitted by the Kansas Department for Children and Families (DCF) and primarily allege beneficiary eligibility fraud. OMIG staff currently screens each complaint received for substance and jurisdiction. If staff determine there is a need for eligibility clarification, the complaint is forwarded to the KanCare Clearinghouse for review and possible follow-up. The number of complaints processed each calendar year represented in the bar chart below.



As noted above, in CY 2022 OMIG processed 1,410 complaints with 1,347 complaints involving allegations of beneficiary eligibility fraud. There were 21 of these complaints that after reviewing the matter did not involve Medicaid and were referred to the correct agency. These typically involved Medicare only. There were also 15 allegations of beneficiaries committing non-eligibility frauds, such as, falsely clocking in a personal care worker. The remaining 48 complaints involved allegations involving providers and contractors.

In CY 2023, OMIG processed 1,447 complaints with 1,377 complaints involving allegations of beneficiary eligibility fraud. There were 38 of these complaints that after reviewing the matter did not involve Medicaid and were referred to the correct agency. There was one complaint involving a state agency and two involving state employees. There were also 14 allegations of beneficiaries committing non-eligibility frauds. The remaining 53 complaints involved allegations involving providers and contractors.



The breakdown for the how the complaints for CY 2022 and CY 2023 were handled are broken out in the chart below. It must be noted that the public health emergency (PHE) impacted the determination for many allegations. For example, allegations of being over income during the PHE were not considered fraud due to rules in place at the time. The "No Fraud/Jurisdiction" determination is based on our preliminary review of the matter. The referrals sent to the Clearinghouse for additional review may result in additional determinations of no fraud or possible fraud. If staff at the Clearinghouse and KDHE determines there are indications of fraud, they will refer the information back to OMIG for further consideration. OMIG investigative staff came on board in July of 2023. They are addressing the backlog of open cases and processing new allegations as they are received.

Calendar Year	Complaints Screened	Eligibility Complaints	Sent for Review (CH)	No Fraud/ Jurisdiction	Investigations Opened	Referred to Other Offices
2022	1,410	1,347	1,059	221	27	40
2023	1,447	1,377	1,048	191	112	70

CY 2023 Oversight Activities

The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight is a standing committee of the Kansas State Legislature. The OMIG has ongoing interaction with the committee to ensure that policy makers are aware of the strengths and vulnerabilities in the Medicaid, MediKan, and SCHIP programs.

In CY 2023, the OMIG attended a total of four committee meetings. During each meeting, the OMIG presented reports from completed work and updates of the OMIG's current activities to the committee. Listed below are the dates of each meeting along with a short description of each activity that was presented to members of the committee.

ID	Date of Meeting	Subject	Type	Formal Report Issued	Report No.
1	02/03/23	Update on Eligibility Audit	Audit	No	N/A
		Update on Transitional Medical Program Audit	Audit	No	N/A
		Update on Multiple Identifications Audit	Audit	No	No
2	04/21/23	Update on Transitional Medical Program Audit	Audit	No	N/A
		Update on Multiple Identifications Audit	Audit	No	N/A
		Update on Eligibility Audit	Audit	No	N/A
3	08/03/23	Audit Report of finding involving Eligibility	Audit	Yes	23-01
		Update on Transitional Medical program Audit	Audit	No	N/A
		Update on Multiple Identifications Audit	Audit	No	N/A
4	10/11/23	Audit Report of findings involving the Transitional Medical Program	Audit	Yes	24-02
		Audit Report for the Multiple Beneficiary Identifications	Audit	Yes	24-01
		Review of COVID-19 Test Kits	Review	No	N/A

The OMIG released three audit reports and one interim report in calendar year 2023. These reports, summarized below, can be accessed at https://ag.ks.gov/fraud-abuse/medicaid-inspector-general.

Eligibility Determinations, Audit Report 23-01

The audit detailed five findings and made 13 recommendations concerning eligibility determinations for Medicaid recipients who have moved out of the State of Kansas. Our audit covered the period of January 1, 2019, through December 31, 2021. The audit identified internal and external deficiencies that hinder KDHE's ability to identify, verify, and terminate Medicaid eligibility on a timely basis. For example, a group of beneficiaries that were identified as moving out of Kansas were not properly processed, resulting in an estimated overpayment of $1,370,376.68 in capitation payments to MCOs.

Multiple Medicaid Beneficiary Identifications, Audit Report 24-01

The audit detailed two findings and made seven recommendations concerning KDHE's system for tracking Medicaid beneficiaries with multiple Medicaid identification numbers and KDHE's

process for recouping capitation overpayments to MCOs. The audit found that only 3 instances out of 53 (6%) cases reviewed with multiple beneficiary identifications had been recouped in a timely manner during the designated audit period of January 1, 2019 to June 30, 2022. After accounting for the 8 (15%) who had fee for service, 42 (79%) were left with no capitation recoupments totaling $95,145.21 from the MCOs. There were also 57 instances of one SSN connected to multiple beneficiary identifications. KDHE's correction efforts, following the start of our audit, resulted in 13 beneficiaries whose capitation payments were recouped or stopped. We determined that the savings for a one-year period totaled $105,255.72.

Transitional Medical Program (TransMed), Audit Report 24-02

The audit detailed five findings and made 15 recommendations concerning KDHE's system for processing and tracking determinations for Medicaid beneficiaries on the TransMed program. The number and types of findings identified during the audit indicated control weaknesses placing Medicaid monies at risk. We identified significant compliance and control gaps within the TransMed program. A lack of oversight has led to staff misunderstanding, which has contributed to a 45% error rate within the TransMed program. We also identified a lack in targeted reviews aimed towards resolving eligibility issues related to the TransMed program.

We identified numerous households that went without a review for several years prior to the declaration of the Public Health Emergency (PHE). Out of the 53 review errors identified in our sample, over 50% of the affected beneficiaries have gone without a review since the 2015-2019 timeframe. We identified 9,322 beneficiaries who were enrolled in TransMed during our audit period of January 1, 2019, through December 31, 2021, and had 13 months or more of continuous TransMed coverage. Beneficiaries are limited to only 12 months of continuous coverage. We considered the COVID-19 Federal PHE that was declared in March 2020, and narrowed our review sample to only include the 2,322 beneficiaries who had unallowed coverage prior to the PHE.

Our review identified $16,326,364.59 in estimated capitation payment overages as being wasted on ineligible persons as of June 2022. We extrapolated 25% from the original 2,322 beneficiaries, leaving 580 who potentially continue to be covered through TransMed. The average monthly payment per beneficiary in June 2023, was $452.56. The savings in capitation payments for terminating beneficiaries who have remained on TransMed since prior to the PHE would be an estimated $1,574,908.80 over a six-month period.

School Background Checks, Interim Audit Report

The interim report contained information developed during our performance audit of the KDHE's management of School-Based Fee-For-Service (FFS) Medicaid reimbursements for the

State of Kansas. The scope of our audit included all Medicaid enrolled students who had services billed on their behalf from a Local Education Agency (LEA) provider within a school-based program from January 1, 2021, through January 31, 2023. Approximately, $23.5 million in Medicaid funds are dispersed via Fee-For-Service (FFS) to Kansas school districts each year to reimburse them for providing services to students that are on Medicaid.

Medicaid funded services are performed by various providers who are employees of the school districts or are contractors. We discovered that of the 231 providers reviewed as part of our audit sample, 72 or 31% did not have proof the background checks were completed at the time of our request for records. Also, five schools completed background checks on 14 providers after receiving our request for records.

Our sample of providers was taken from 17 of the 287 public schools across Kansas. We added one additional school-based program for a total of 18, due to an associated school cooperative (Co-Op). Schools were picked at random, providing a cross representation in total enrollment and geographical location across the state. It is estimated there is an average of 13 providers per school district in Kansas. Accordingly, there is an estimated total of 3,731 providers working directly with children in Kansas public schools. Our sample testing indicates that 31% or 1,157 of those providers may be working without a background check.

The Kansas State Department of Education (KSDE) requires a fingerprint-based criminal history check for licensed staff. There are no State of Kansas statutes that require these checks. We did not find any state level requirements for other school employees to have background checks. This includes other employees, such as, therapists, coaches, paraprofessionals, bus drivers, cooks, and janitorial workers.

Our research found an attempt to make fingerprint-based checks a statutory requirement. Senate Bill 70 was introduced January 26, 2015. The bill would have required every teacher to have a fingerprint-based background check at the time they apply for their initial teaching license and every time they renew their license (every 5 years). It would also have required teachers convicted of any crimes listed in K.S.A. 72-1397 9(a) or (b), or who entered into a diversion after having been charged with a crime listed in (b), to notify the Kansas State Board of Education and their license would have been revoked. It passed the Senate. On March 23, 2015, it was recommended that the Committee of Education pass the bill as amended. On March 25, 2015, it was stricken from the calendar because of timeliness rule #1507.

We made the following recommendations:

1. All school districts immediately confirm that all employees, regardless of role, have current background investigations on file.

2. All school district employees have fingerprint-based criminal history background investigation performed on a regular, documented cycle of every five years.
3. Fingerprint-based criminal history background investigations on a five-year cycle be a statutory requirement for all school employees.

Statistics Required by Statute

K.S.A. 75-7427(i) requires the inspector general to include the following information in this annual report:

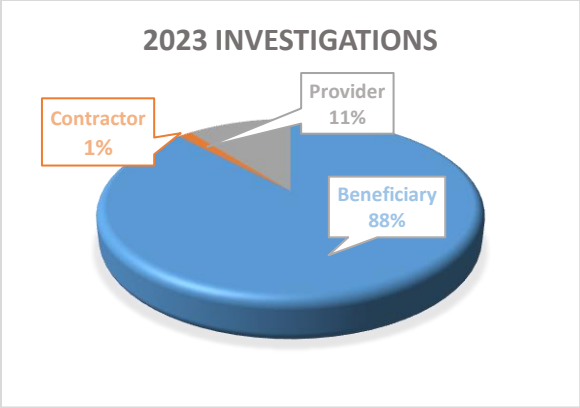
Aggregate provider billing and payment information. The OMIG has obtained the following FY 2023 aggregate provider billing and payment information from KDHE's website.
Total Medicaid provider payments: $5,429,434,408.00
Total MediKan provider payments: $5,464,895.00
Total SCHIP provider payments: $138,941,884.00
KanCare Capitation Payments:

Total Medicaid managed care capitation payments: $4,640,933,249.00
Total SCHIP managed care capitation payments: $137,801,613.00

The number of audits of Medicaid, MediKan, and SCHIP and the dollar savings, if any, resulting from those audits. Three audit reports were published and one interim report released in CY 2023. Summaries of the reports are detailed above. OMIG identified $16,326,364.59 in wasteful spending, $1,465,521.89 in overpayments, $1,680,164.52 in potential savings, 12 findings, and made 38 recommendations.

Health care provider sanctions, in the aggregate, including terminations and suspensions. No providers were sanctioned as a result of OMIG activities in CY 2023.

A detailed summary of the investigations undertaken in the previous fiscal year. During FY 2023, the OMIG focused the majority of its attention on audits and reviews. The OMIG also did not have special agent or analyst staff approved to conduct investigations for FY 2023. However, in anticipation of adding investigative staff, the OMIG opened 75 investigations in FY 2023, with 66 of the investigations involving Medicaid eligibility fraud, one involving a contractor, and eight involving Medicaid providers.



OMIG closed 18 of the cases, with four of them closed with the allegation disproven. Four were also closed due to insufficient evidence being available to develop the case further. The remaining 10 cases were referred to other offices for consideration of potential criminal, civil, or administrative action.

Two of the cases opened in FY 2023 have been referred to prosecution with the outcome pending. A case that was opened in FY 2022, where the subject provided false income and household composition information in order to be placed on Medicaid and to receive food assistance illegally, resulted in a diversion agreement.

The remaining 57 cases are being investigated by staff brought on at the beginning of FY 2024. Additional cases are being opened and assessed based on referrals received in FY 2024.